The condition is observed sometimes in the late teens but more commonly in the 20's, 30's and 40's and somewhat less commonly in the older age groups. Various complaints may bring the patient to the doctor. The patient commonly complains of fatigue without much else to go with it. This he frequently terms "lack of pep," loss of his usual ambition both at work and play, sometimes a moderate loss of libido, frequently a mild low backache in the sacral area which is worse in the morning upon arising and improves after some physical activity and moving about in the morning. This type of individual will have completely negative physical findings and the urine is also usually completely negative. Unless the doctor is thinking of prostatitis as a possibility he will miss the opportunity to make the diagnosis at this stage. The prostate is ordinarily not remarkable to palpation and it is only upon purposeful milking of the prostatic secretion and examination under the microscope that the diagnosis of prostatitis can be made. About half of the group will have some associated urinary symptoms which are in the nature of frequency, urgency and dysuria.

Patients with such symptoms usually are seen by urologists and the two-glass urine test will show a significant number of pus cells in the first glass with definitely less or none at all in the second glass of urine. Here the clue is obvious and a prostatic massage with the obtaining of the prostatic secretion for examination is all that is needed to make the diagnosis.

In my experience fewer than 25 per cent will have noticed any urethral discharge in association with the above symptoms. Cases in which there is urethral discharge are not necessarily cases of chronic prostatitis; they may be owing to psychosexual disturbance. The distinction is easily made by the above mentioned methods. A signicant number of patients with chronic prostatitis whose symptomatology is outlined here, will not show more than an occasional pus cell in the prostatic secretion in the first specimen obtained by massage. Sometimes even the second specimen three or four days later will have few pus cells, but the third massage will usually produce the typical flood of many pus cells in the prostatic secretion. The lesson here is that if the story is very typical, one should persist in several diagnostic massages until prostatitis has been definitely ruled out.

Acute prostatitis is not, as is implied by the author of the article, an entirely different condition; and, contrary to his statement, I believe that acute prostatitis will usually not respond to the antibiotics. My own experience, over a period of about the same length of time that the author mentions, is that in fewer than 20 per cent of cases will there be any real change in the prostatic secretion with any type of antibiotic. Antibiotics should be used, however, because in these cases the bladder, especially the trigone and sometimes the kidney pelves, are involved in the infection and there is associated fever, leukocytosis, increased sedimentation rate and sometimes epididymitis. All of these complications (because that is what they are) of prostatitis will respond to the sulfonamides or the antibiotics quite promptly. What remains after the acute phase is over is chronic prostatitis and that the prostate gland is quite vascular is true from the surgical standpoint, but his intimation that the antibiotics administered by mouth or parenterally infuse the gland in adequate concentration is an unjustified deduction which does not follow the observations of other investigators. In fact, the contrary can be more logically assumed.

The most important point, I think, that should be made about prostatitis, either acute or chronic, is that it is the cause of the overwhelming majority of symptoms in the urinary tract of the male. General practitioners could deal with this large percentage of the urological problems presenting themselves if they would use a step-by-step procedure which includes physical examination of the genitalia, a two-glass urine test and a thorough prostate examination both by palpation and a stripping of the gland to obtain the prostatic secretion for microscopic examination.

Finally, it is perfectly patent that the treatment of prostatitis leaves much to be desired. Prostate massage, done properly, remains the basic treatment. Other procedures such as urethral calibration with sounds to rule out strictures and the treatment of complications with sulfonamides and antibiotics are necessary, but most of the other things such as irrigations and instillations have fallen by the wayside. A significant number of patients who do not respond to the standard methods can be cured by the direct injection of the prostate through the perineum with a spinal-type needle, using such antibiotics as penicillin, neomycin or terramycin.

Despite all the shortcomings of the treatment of prostatitis, I feel that it is quite important not to confuse the profession with articles such as this for the reasons that I have tried to outline above.

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Editor, CALIFORNIA MEDICINE:

THANK YOU for your kindness in permitting me to answer Dr. Burns' letter. Careful reading of my paper would demonstrate immediately that the term "prostatosis" was suggested as a substitute for "prostatitis" precisely because of the greater ac-

curacy of the word "prostatosis." The word "prostatitis" is used in the title simply because nearly everyone employs it. This is not a mere semantic differentiation, because my entire concept is based upon the opinion that "chronic prostatitis" is largely not infective in origin. To repeat the summary of the paper, " 'Chronic prostatitis' unaccompanied by signs of active inflammatory disease is a psychosexual disturbance, not a bacteriologic disease. Prostate massage, local therapy, and antibiotic therapy are usually of no therapeutic value; a careful history and evaluation of the background and good social and psychiatric counseling are the only effective and rational means by which this so-called 'prostatitis' is controllable."

Specifically, in answer to some of the details raised by Dr. Burns, the prostate gland is not singularly immune to antibiotic drugs which penetrate all other vascularized tissues. Unless a true abscess is present (which is rare), oral and parenteral antibiotic drugs are present in the prostate gland in adequate concentration. Simultaneously performed penicillin assays on blood and prostate fluid, in a patient receiving penicillin, will demonstrate adequate penicillin levels in the prostate fluid. Prostate fluid leukocytes ordinarily do not diminish in number after antibiotic therapy because usually they are not caused by infection. Bacterial cystitis and pyelonephritis are infections which will respond to correct antibiotic therapy. The concept that "chronic prostatitis" is simply a residuum of acute prostatitis is erroneous.

I have not seen a documented series of patients who were "cured" after direct injection of drugs through the perineum into the prostate gland with a long needle. If this must be performed, I would suggest the use of a panendoscope plus the "flexible infiltrating needle," A.C.M.I. catalog No. 193, which should accomplish the same purpose more accurately and elegantly, less dangerously, and with diminished medicolegal hazard.

I do not understand the several contradictions in Dr. Burns' letter. First he states that "the urine is also usually completely negative" and then says that "the two-glass urine test will show a significant number of pus cells in the first glass." It states that one must "persist in several diagnostic massages until prostatitis is definitely ruled out, then a "typical flood of pus cells will be produced after prostate massage every 3 or 4 days" from a prostate gland which "does not show more than an occasional pus cell in the prostate secretion in the first specimen." Which is correct? What is the "obvious clue"? The prostate gland consists of living tissue which becomes edematous and inflamed after injury. Certainly, vigorous prostate massage "every 3 or 4 days" will produce "a typical flood of pus cells." The correct term should be "traumatic prostatitis."

My article was written to clarify and to inform and enlighten; it does not "foster misconceptions," nor does it "mislead" anyone. It is not I who is confused.

DAVID ROSENBLOOM, M.D.

July 15, 1955.